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THE VETERANS REHABILITATION CLINIC
MOUNT ZION HOSPITAL, SAN FRANCISCO, CALIFORNIA

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BULLETIN of the
MENNINGER CLINIC

VOLUME 9 JULY, 1945 NUMBER 4

FOREWORD

By KARL M. BOWMAN, M.D.*

Much has been said and written concerning the problem of the returning veteran. It has been pointed out that a very high percentage of those being returned as casualties from overseas and those being discharged from the Armed Forces are rated as neuropsychiatric cases. This fact has been seized upon by many alarmists to indicate that the country will shortly be overrun by hundreds of thousands, if not millions, of seriously sick mental patients. Without adequate understanding of the situation, many persons have become panicky, have assumed that there is a tremendous increase of mental disease in the Armed Forces and that extreme measures must be taken to deal with this situation. All this has been carried to an absurd extreme and it is time that the people should have a clear understanding of the facts.

In the first place, the neuropsychiatric discharges include those for mental deficiency (feeble-mindedness), the organic neurological conditions without mental symptoms, the unstable and inadequate personalities, the psychoneurotic and the psychotic. A discharge on psychoneurotic grounds means only that the individual is not suitable for further military duty. Many of these individuals had mild personality difficulties or psychoneurotic reactions prior to coming into the service. They have not been harmed by the service and they return to civilian life essentially as they were upon entering the service. The psychotics represent an extremely small group. They are either cared for in hospitals or have recovered and are back in the community. The problem is essentially the same as the one we have in the discharge of patients from our State hospitals.

Many of the psychoneurotics had this condition before service, are able to return to their previous employment, and will make the transition with no particular difficulty if they are left alone. This does not mean that there is not a large number of persons being discharged from the Armed Services who need psychiatric care and treatment. The number is sufficiently large to disturb any serious student of this subject. However, it is important that we keep a sense of proportion.

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One of the first points we need to keep in mind is that people tend to react according to what society expects of them. This is true of the psychoneurotic even more than of the normal individual. Therefore, if we assume that everyone returning with an N. P. diagnosis is a chronic mental invalid incapable of going to work, and in danger of acute mental outbreak, we shall merely foster such reactions on the part of these individuals.

The general public must be told that the returning veteran should, ordinarily, be treated as a normal human being. Many men in the service are becoming upset and irritated at the artificial attitudes many well-meaning people are assuming toward them. Our method of dealing with the returning veteran, therefore, should be to treat him as a normal individual and to expect him to act as such. If there is any indication that he needs psychiatric care, we should arrange for him to receive it immediately. It is well known that any type of psychiatric treatment has its greatest value if applied at once. The returning veterans who need psychiatric treatment should have this available the minute they return and every effort should be made to see that they get it. Unfortunately, this is not being done generally and there are comparatively few well-organized psychiatric clinics open to the returning veteran. It would seem that the Veterans' Bureau might well follow out the plan which it started after the last war of utilizing civilian psychiatrists and setting up psychiatric clinics in connection with good medical schools and hospitals. This removes the military atmosphere which many of these men find distasteful. One such endeavor is the clinic which has been established at Mount Zion Hospital, San Francisco. Here a group of competent psychiatrists are available to treat the returning veteran who is suffering from some psychiatric condition.

The papers that follow will give some idea of the organization of this clinic, the important work that it is doing and the results that have been achieved so far. We need many more clinics of this sort to deal adequately with this problem.

VETERANS REHABILITATION CLINIC OF MOUNT ZION HOSPITAL

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Dr. Emanuel Windholz, Chief Psychiatrist
Miss Charl Rhode, Chief Psychiatric Social Worker
Mrs. Murray Draper, Secretary

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THE ORGANIZATION OF THE VETERANS REHABILITATION CLINIC OF THE MOUNT ZION HOSPITAL

By J. S. KASANIN, M.D.*

At the beginning of the war civilian psychiatrists had the opportunity of serving the country by taking an active part in civilian defense, thus strengthening the morale of their own community. As the danger of immediate invasion and bombing became more remote, we were all confronted with the problem of what we as civilian psychiatrists, psychologists, and social workers could contribute toward the most effective prosecution of the war. The opportunities for this presented themselves in San Francisco quite early in the war.

Numerous patients began to appear whose problems were directly connected with the present conflict. Three groups of cases presented themselves. The first group consisted of men who were rejected by the induction boards as unsuitable for military service because of various neuroses and psychoses. These men felt guilty and rejected; they were ashamed to return to their own communities and preferred to remain in the city. With their quick absorption into war industries, many of them made satisfactory adjustments and as time went on their problems were not so serious as others which began to appear. The second group were war wives, young married women who developed various types of neurotic reactions in connection with the departure of their husbands overseas. Both clinic and private psychiatrists began to be flooded with patients referred by the outpatient departments of the Army and Navy and various service organizations, and this group was studied intensively by one of us (JSK). The third group were the men who were discharged from the armed forces on account of neuropsychiatric disability. It had not occurred to us that this would be a very serious problem and neither the community nor the government agencies were prepared for such a large influx of cases. In recent months the number has gone as high as 30,000 men and women discharged monthly from the armed forces as psychiatric problems. With the appearance of an increasingly large number of cases, there arose not only the question of numbers but also of certain special problems characteristic of those patients who come to the various clinic and private psychiatrists. It was noticed by the writer, and probably by many other psychiatrists, that these patients coming to the clinic or to a private office would state their problems, describe their symptoms, and then would not

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return for further treatment. When we began to inquire as to why these patients did not come back, we learned that they felt guilty about not being in the war, about being discharged from the armed forces, about deserting their fellow comrades, and that they could not face other civilian patients in a waitingroom.

At the same time other attitudes appeared which were even more serious. Many of these men were quite antagonistic and hostile. They complained that the Army was no good, that the officers were no good, and that the treatment was poor. Interestingly enough they were just as hostile toward civilians as they were toward the Army. It occurred to one of us (JSK) that this was potentially a dangerous reaction, since they could easily become anti-social on the basis of their neurotic conflicts. It was these attitudes which made us feel that special measures should be taken to help these veterans change their feelings through treatment of their individual problems.

Organization

For this reason we began to agitate for the formation of a special rehabilitation clinic for discharged veterans suffering from various types of neuroses. We felt that we ought to have a full time psychiatric rehabilitation clinic both for the study of such reactions as described above and for the development of effective methods of therapy, especially therapy utilizing group techniques. To this end, we began a search for special funds to organize such a clinic and finally the Columbia Foundation of San Francisco came to our aid with financial assistance for this purpose. Later on it was stressed by practically all military psychistrists that the best way in which civilian psychiatrists could serve the country and the war effort was by giving as much of their time and effort as possible to the work of rehabilitating veterans suffering from psychiatric conditions.

Our clinic began to function on June 1, 1944, with the writer as director in an administrative capacity, a half-time chief psychiatrist, a full-time chief psychiatric social worker, a half-time secretary, and a corps of volunteer psychiatrists and psychiatric social workers.

This was the second full-time psychiatric clinic for veterans in the country, the first being one organized by Dr. Thomas Rennie of the New York Hospital in August 1943. Immediately prior to the organization of our clinic I visited Dr. Rennie's clinic, and in its external aspects our clinic is very much like the New York clinic. We are very grateful to Dr. Rennie and his staff for their many valuable suggestions.

The Clinic operates all day every day, and there is a special evening clinic every Thursday night for the benefit of those men employed in industry. Group therapy is conducted on other evenings of the week.

Very soon after the organization of our clinic our limited staff became overloaded with work. The term "half time" became a mere figure of speech, as every one of the personnel of the clinic worked even more than "full time." In addition to this practically every psychiatrist and psychiatric social worker in the Bay Area who was not too tied up with other evening responsibilities joined the staff of the special clinic held every Thursday night.

The standard procedure used in all psychiatric clinics has been adopted in our clinic. Patients are interviewed by the chief psychiatric social worker; each patient is seen by Dr. Windholz, chief psychiatrist, and then is either carried in treatment by him or is referred to one of the volunteer psychiatrists in the evening clinic. Each case is discussed in conference, careful notes are kept, and the study of the background of the case, as well as a certain amount of therapy, is done by the psychiatric social workers. We have special provisions for psychological testing of selected cases by a corps of volunteer psychologists headed by Dr. Robert Harris of the Langley Porter Clinic.

Quarterly reports are sent to the Director of the Mount Zion Hospital, to the Research Committee and members of the Advisory Committee of the Hospital. As it is now constituted, the Rehabilitation Clinic is a part of the Department of Psychiatry of Mount Zion Hospital, and is carried as a special research project by the Hospital. There is an advisory committee composed of representative citizens.

Objectives

The objectives of the Clinic are research into the causes of the various types of war neuroses, a better understanding of the clinical pictures seen, and careful study of the most effective methods of treatment of such war neuroses. Psychiatrists representing various therapeutic schools are members of the Clinic. Their opinions and efforts are pooled and therapeutic results, both negative and positive, are discussed and evaluated and suggestions made for further development of treatment techniques. Aside from rendering a service to the veteran the Clinic has been of great importance in organizing all the younger psychiatrists of San Francisco and the Bay Area into a unified body of men and women engaged in a concerted effort to deal with the mass problem. In this respect the Clinic has been extremely valuable and will probably be instrumental in bringing about the development of a central psychotherapeutic institute. It has demonstrated to psychiatrists that they can work much better if they work together in a lively exchange of ideas and opinions.

During the first few months in the work of the Clinic a great effort was made to educate the various social agencies and veterans' organizations

of the community as to the function of such a clinic. At the same time personal contact was made with the various Army and Navy posts in Northern California and the whole program was carefully discussed with the representatives of the military. Col. Lauren Smith, the Neuropsychiatric Consultant of the Ninth Service Command, has been extremely helpful in our work with the Army. With the staff finally organized, cases began to come in steadily and in gradually increasing numbers and we are now receiving a good selection of treatable cases. Thus far, in ten months of operation, we have seen 230 cases, representing a complete cross section of races, nationalities, localities, social status, etc. Whereas in the beginning most of the cases were men discharged from the armed forces without having been overseas, we are now receiving more and more cases with combat experience and with a service record of several years.

Evaluation

A complete evaluation of our therapeutic efforts is difficult to make because of the constant change in the character of our cases. Many factors are involved: age, duration of neuroses, type of injury, existence of previous neuroses, etc. We believe, however, that we have helped about 75% of the cases, with varying degrees of improvement noted. In some there was a spectacular cure after a few sessions, while in others only a moderate improvement was achieved with much more expenditure of time and effort. One outstanding technique used in our clinic is that of the intensive application of group therapy developed by Dr. Windholz. Another important factor formulated in our Clinic is that of "selective rehabilitation," whereby a man is adjusted to industry by taking into consideration his neurotic problem rather than ignoring it—as is so often the case in vocational rehabilitation. We have seen many men who have failed on the job ten or twelve times and only after selective rehabilitation such as that developed in our clinic were we able to help these men.

As the result of the very rapid growth of the Clinic and the awareness of it by the community, numerous requests have come from industry to train their counselors in dealing with the problems of adjustment of war veterans to various jobs. We have had such requests also from local rehabilitation divisions of Army, Navy and Marine Corps. It became obvious to us that rehabilitation is not the problem of any one clinic or of any one group, but requires a concerted community effort. We have been very fortunate through the efforts of Miss Charl Rhode, our chief psychiatric social worker, in integrating our clinic in the community. We have had excellent cooperation from the local chapter of the Veterans' Bureau (which sends us a great many cases) as well as from various other organizations. As the problem unfolds itself and more and more veterans

come into the community, it is obvious that the psychiatric rehabilitation of such veterans should be the responsibility of the Government.

It is our hope that the community, as well as public opinion, will convince the government of its obligation to support financially the various rehabilitation clinics like ours throughout the country, whose work has been lar ely on a volunteer basis.

Many interesting studies have been developed by the Clinic which we hope to publish. The staff is engaged now in the comparison of various methods of group therapy, the relationship of cultural and social backgrounds to the development of subsequent war neuroses, and a classification of the war neuroses such as has been suggested in the accompanying paper by Dr. Windholz.

In conclusion, I would like to emphasize again the excellent cooperation we received from the Hospital administration, from the Jewish Family Service Agency (in whose building the Clinic is located), from our Advisory Committee, and especially from the loyal and enthusiastic staff, both full time and volunteer, in carrying out this very important work.

OBSERVATIONS ON PSYCHIATRIC REHABILITATION OF VETERANS

By EMANUEL WINDHOLZ, M.D.*

> . . . it should be the responsibility of the military authorities to insure that no overseas casualty is discharged from the armed forces until he has received the maximum benefits of hospitalization and convalescent facilities, which must include physical and psychological rehabilitation, vocational guidance, prevocational training and resocialization.
>
> Franklin D. Roosevelt
> From a letter to the Secretary of War.

We have seen 230 veterans† in the first ten months. Our most urgent task was the search for short-term treatment procedures which would utilize all means available—psychiatric and sociological—to help the veteran in his adjustment problem. The concept of rehabilitation has been molded and re-molded in long discussions with our staff.‡ At first our aim was to bring the veteran back at least to the level of his pre-war adjustment capacity. This concept is misleading, if it means to bring back the pre-war adjustment. After spending years away from their families the veterans are changed individuals. During their absence their families and communities have also changed. The so-called "old job" is either not available or is not the same as it was prior to the war; the plants have been reconverted; the work is different; the employees have changed, etc. Some of the young boys are faced with entirely different problems of adjustment than prior to service. The pre-war adjustment of others was so bad that no one would like to see them in the same predicament again. In a rehabilitation program all these factors have to be taken into consideration.

The different therapeutic procedures which we use in our Clinic constitute only a small part of the rehabilitation program which will be outlined in the following paper by Miss Rhode. We applied mostly short psychotherapy which was supplemented in some cases by group therapy. In a few cases we used hypnosis. We are introducing now pentothal.

We are making an attempt at a classification of the different types of

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† The term "veteran" is used loosely in this paper to cover discharged servicemen and women and also merchant seamen released from duty.

‡ The work of the Clinic was possible only through the excellent cooperation of the volunteer staff, who helped us also in the formulation of our ideas. We wish to acknowledge the help of Mr. Erik H. Erikson in the preparation of this report.

war neuroses. On the basis of their etiology and psychopathology we hope to establish appopriate forms of treatment. We put great emphasis on the recognition of psychodynamic factors in war neuroses. The clinical picture of a war neurosis is usually determined by the individual's pre-war personality and depends on the particular defense mechanisms which were at the man's disposal prior to service. These mechanisms are put out of action when neuroses develop in combat experience, but after the anxiety subsides the original defenses are again mobilized and usually dominate the clinical picture. In other instances a regression sets in and with it a revival of other mechanisms of defense, resulting in some cases in the development of psychoses. Since most of these are soon hospitalized we did not have an opportunity to study a large number of psychoses. We have seen a few cases in which the psychotic mechanism was merely intensified in service or after discharge; in others, this was the first psychotic episode. Some of them improved remarkably after a short treatment period.

Types of Cases Seen

In this paper we shall describe an "hysterical psychosis", a clinical picture which seems to have no connection with the individual's pre-war personality, and after making some general observations as to the types of cases seen we shall give an example of a traumatic war neurosis, characterized by a "counter-phobic attitude" and the tendency to project guilt and aggression; an example of the opposite type, the mechanism of introjection, turning aggression against one's self—the depressive type; and finally a brief picture of a compulsion neurosis. One example of "selective vocational rehabilitation"—an attempt to use the psychodynamic factors in vocational planning—will be discussed. There is one advantage in observing, even superficially, such a large number of cases. Some common features can be detected and general principles of treatment and prevention can be outlined. Before describing these conclusions, we shall give an excerpt from a discussion of problems of compensation in group therapy. Group therapy appears to be also the appropriate form of preventive treatment prior to discharge.

In a large percentage of veterans who came to the Clinic a few weeks—not more than two months—after discharge, we observed an interesting picture of an "hysterical psychosis." We could not find any typical connection between this reaction and the individual's neurosis. Some of these cases—several among them were women—were not overseas and did not have particularly upsetting experiences in service except great disappointment, but all of them suffered from intense conflicts with regard to their adjustment to civilian life. Others spent considerable time overseas, having

been exposed to discomforts, deprivations, and the stress of combat. Since we have seen it in such a variety of cases, we are inclined to believe that the pathology is not specific. From the therapeutic results, which are complete at least with regard to this particular symptom, we believe that the outstanding causative factor is a conflict related to discharge: ambivalent feelings about their rights to be in or out of service, and demanding attitudes toward both civilians and Army. Torn between these desires, such individuals escape into a dreamlike state for a few days or weeks. The clinical symptoms are a dreamy appearance, slight disorientation, and depersonalization. To the unskilled observer, they appear just absent-minded. The symptoms may disappear without treatment. A recovery is achieved promptly if the individual can verbalize the ambivalent feelings.

One group of young veterans enlisted in the Armed Forces in the hope of finding three square meals a day, a bed, and a home, which they never had before, and of participating in the life of "grown-ups", in the expectation of growing up themselves. Many of these individuals are without parents, or left their homes in adolescent rebellion, or were reared in orphanages or foster homes and went into the service direct from C.C.C. camps. Some of them offered a great deal to their country; some of them distinguished themselves; after discharge, they feel abandoned again. They grasp at the opportunity of training for a job or of continuing their education. If we observe them closely we see that they are only marking time, that they are incapable of developing lasting interest in schooling or vocational training. The rehabilitation of these individuals must include a "placement" in the community, the creation of a social setting which provides what they need—a home or a substitute for it, as described further in the article by Miss Rhode which follows.

The merchant seamen who were in service before the war are often in an even worse situation. It is obvious that once they break down and cannot go back to sea they are like people who have been "bombed out" of their homes. The rehabilitation of Negro veterans has far-reaching implications, since the problems of racial prejudice are beyond the scope of our Clinic. We were fortunate to have several Chinese social workers, who made it possible for us to work with Chinese veterans.

With a limited number of veterans characterized mainly by their aggressive behavior and resentment toward the service and civilians as well, we can achieve the following therapeutic result in a very short time: We can bring them to a realization of their basic insecurity so that they can recognize the infantile source of their dissatisfaction. Individual treatment can be of no further benefit to them unless they too can become a part of a group, in a setting in which they can find an outlet for their

aggressions. They ought to be in some type of cooperative project in which they can use their initiative and prove themselves.

For purposes of research psychoanalysis of combat neuroses would be of the greatest importance. Since we cannot spend so much time with one case, we attempt a careful study of the veteran's personality, his childhood, and the exact circumstances of his breakdown. In the few selected cases where we could do this thoroughly we arrived at interesting conclusions as to the relationship between the traumatic war neuroses and infantile neuroses.

Projection of Guilt: The Aggressive Type

Here is an example of a traumatic war neurosis, a neurotic defense, in which a well-functioning "counter-phobic attitude," (Fenichel) has been put out of action.

Case 1. This is a 30-year-old veteran, a sergeant attached to the Medical Corps, who broke down more than a year after his first combat experience. At four o'clock one morning, while he was attending the wounded, the enemy suddenly broke through and overran the place. There were "millions of holes" in his tent; he was wounded, turned off the light quickly, and fell to the floor. A Japanese soldier broke into the tent and killed those who showed signs of life, while he, lying on his stomach, his wounded arm under his chest, the blood running down his leg, kept still, pretending to be dead. Twelve were killed in his tent, among them several of his buddies. They had to wait fifteen hours for help, "with all those dead around us." The commanding officer, "a very nice guy, the best we ever had," was killed. Another captain, "the worst we ever had," took over. This captain blamed the platoon sergeant for shirking his duty and "busted" him to a private. The platoon sergeant couldn't take it; he "went nuts" and had to be discharged. After two weeks of hospitalization, patient was promoted to a platoon sergeant, thus taking over the responsibilities of the other whose demotion "wasn't right".

He took all this remarkably well, perhaps because he himself was wounded. He had occasional nightmares, most of which he cannot remember, yelling out in his sleep, "The Japs are coming." Except for his irritability, he must have done a satisfactory job, since he participated with his outfit in another invasion, which was "uneventful" and lasted only five days.

Two weeks after returning to the base, he broke his wrist while playing baseball. This was an accident, but the patient puts great emphasis on the fact that the X-ray revealed an old fracture of another small bone of his wrist, which he must have acquired during the first invasion. The reason for this emphasis must be in his feelings of guilt over the "accidental" injury. In fact, patient has a history of accidents and, in addition to this "traumatophilic diathesis" (Freud), he has, as we shall see, a number of individual characteristics of the "fracture group," as described by Flanders Dunbar. He was hospitalized, operated on, his arm put in a cast, and two months later he had his first severe anxiety attack. It occurred under the following circumstances: He was lying on the lawn in front of the hospital on his arm (cast), in the same position he was in on that fateful night when he expected to be killed by the Japanese who stood behind him; he was talking to a friend about a baseball game they expected to see soon—a team coming from the U. S. A. to entertain the boys;

suddenly, his heart started to pound and he felt terrified. Six months later, he was discharged.

PRESENTING SYMPTOMS

He came to our Clinic a few weeks after discharge, presenting a combination of symptoms of a traumatic neurosis and a psychoneurosis and the transient "hysterical psychosis" described above. He had frequent "heart attacks," was terrified by nightmares, was restless and confused. He was overwhelmed by feelings of resentment against the Army and he could hardly keep from swearing and blaming everybody: "They drive you crazy. There were a hundred men in my company; twelve were killed in my tent. That is not enough. They send you into action again and again. Why don't they exchange the soldiers instead of using them over again for so many invasions? Most of my buddies are dead or badly wounded. Only a few are left. They have to go on fighting. I am getting letters from them and it makes me mad." He never tires of talking about this, blames the Government for the war, and the doctors in service for making money. He gets particularly heated when he starts to talk about the "nasty" captain who "busted" the sergeant whose place he took. He tells of a boy who wanted to shoot this captain and says that he stopped him, but soon he adds: "He should be dead. Every time I think of him I get mad. I hated the guy. I don't hate anybody, but he was terrible. He wanted to get ahead. *He would have killed his own mother.*"

He is constantly preoccupied with the war; he follows the news carefully to find out where his outfit is fighting now; he is in continuous correspondence with his buddies, and he comes closest to describing the relationship between his symptoms and his feelings of guilt by saying: "I would rather be dead than be out there." Of course, he does not recognize that the superficial reason for his being afraid of dying might be because he feels he deserves death for not wanting "to be out there." It would be useless to attempt to point out to him that he is defending himself and is afraid of being blamed. He cannot even consider such an idea without "blowing his top"; it is simply intolerable. However, it was possible to show him how the fear of a heart attack can be brought about almost experimentally: In the midst of an outburst of temper, he invariably developed a pain in his heart and started to have spells. Finally, we reached a point where he could verbalize the following feelings, which marked a turning point in his treatment and the beginning of improvement: "I hated to go to war. I could have been one of these conscientious objectors, but nobody would understand. They think you are 'yellow'. It is a strange feeling when the boys are dying right and left and you are saved, as if you were singled out for something, for some big job, for your country, for the boys of the future generation. They should be saved from another war. People forget easily what happens. I don't want to forget."

CHILDHOOD MEMORIES

The patient's memories about his parents are colored by his need to prove that they are fine people and did everything they could for him. He was very attached to his mother, who suffered all her life from high blood pressure and *pains around her heart*. He felt sorry for her, tried to help her, but once he was out of the home he forgot all about her. As a matter of fact, on the street he seemed a completely changed person. At home he had to keep quiet and be considerate; outside he was reckless. "I was a fool; just a screwball. I did anything if somebody dared me."

At the age of eight he took an umbrella and jumped from a building—30 feet high (?)—just to prove that he wasn't afraid. We understand why he wanted to join the paratroopers after he was drafted; his mother would not allow this. At the age of six he had a tonsillectomy. He yelled and screamed when they took him to the operating room. Several months later he bragged in the streets of his ability to hold a firecracker between his teeth (a denial of his fear of the operation). He was always active and restless. He was boisterous, believed in his good luck, and was sure he could achieve anything he wanted—just like an adolescent. This is a typical "counter-phobic attitude." The counter-phobic attitude was probably erected against the patient's infantile terrors.

In his early childhood the patient suffered from nightmares, from fear of the dark, of ghosts and of noises. He remembers a nightmare which occurred at the age of four: "A giant was straddling the foot of my bed, an old-fashioned double bed. He had green eyes and was staring at me. I was terrified, woke my father and told him to look." He slept with his father alone while his mother was in the hospital giving birth to a girl. It is easy to interpret such classical infantile night terrors, in which the child hears, sees, or imagines what is happening but is unable to move and is paralyzed by anxiety. The similarity of these experiences with his combat experience is obvious. The feeling of helplessness is an outstanding characteristic in every traumatic experience. It was even worse in his case. He was forced into complete passivity by another man. He couldn't even move or run or defend himself in any way. The actual breakdown occurred many months later when he was again immobilized in the hospital.

DYNAMICS

The patient gives the following explanation of his breakdown. He says "Everyone there was nervous and afraid—but it was only in the hospital, where it was quiet and I had time to think, that the fear became a problem to me." Then he adds, "A man can take so much and that's all." Obviously he could not prove any more that he was not afraid; his whole philosophy of life crumbled. We believe that the decisive factor was the long period of hospitalization. He could not stand this enforced passivity.

As described by Fenichel, the "counter-phobic attitude" can be maintained only if certain conditions are fulfilled. In our case it was the boy's devotion to his father and the attitude which was derived from it: his over-optimism and faith in his good luck. While talking about his father, the patient uses the same expression with which he characterizes his commanding officer: "A good guy, a nice guy; *you can't beat him.*" He was overwhelmed by his desire to go home—longing for his mother, and the guilt connected with it. His old ambivalence in relation to his father was revived. He lost his faith in his good luck. All this must have been only a repetition of conflicts which were brought about by the original traumatic experience. At that time too he was lying on his stomach, had to keep still, and was forced into complete passivity. The guilt feelings over the death of the good captain were warded off by projection: the bad captain was to blame for everything, while the patient protested his complete innocence. At that time he was able to keep this conflict under control, due to the fact that he was wounded, a punishment for his guilt, and because of his promotion, a partial compensation for his suffering. He couldn't accept this promotion without conflict however, since he was as much afraid of his rebellion as of his desire to submit to authority. He always wanted to be a leader, but never dared to become independent. To be boisterous and show off

were only semblances of masculinity which was permitted only as long as he continued to trust his good luck. Therefore, soon after the promotion he found himself in another dilemma—he was overwhelmed by a fear of his new responsibilities. There is some truth in his statement: "If I had not been promoted to a platoon sergeant, I probably wouldn't have broken down. I was too much worried about my men."

The straw which broke the camel's back was the sudden desire to return home and the realization that he might never be able to play baseball (his favorite game) again. He, who was fighting far away from home, would be unable to compete with the man who had remained at home. The counter-phobic attitude enables an individual to do what he is afraid of doing. After this was put out of action, it was replaced by another defense mechanism: identification. His love for his mother was replaced by an identification with her: the heart attacks are identical with those from which his mother suffered all her life.

Vocational Adjustment

This veteran, like others, was unable to make a proper vocational adjustment because of his conflicting feelings about discharge. He became a storekeeper, in spite of the fact that he had no experience along those lines. He rationalized this by saying that he had to make, in a short time, as much money as possible. The war woud be over and a depression might follow. Behind this facade were his fears of failure, a punishment for his being at home, fear of the boys who would come back and have more rights than he, since they continued to fight. It seemed to us that here, as in a number of other cases, vocational tests should be supplemented by an evaluation of the psychodynamics of the veteran's neurosis. The following factors are important in this case: (1) Since the veteran is unable to stand tension arising from inactivity, he should do something that keeps him fully occupied. (2) His inability to plan and wait suggests a vocation in which he could see the result of his work "growing under his hands"; he should have the satisfaction of it immediately. (3) He would enjoy this more if he could work with others in order to satisfy both his need for companionship and the tendency to show off. (4) His interest in children, and particularly the need to mother them, suggests a vocation in which he could create something, produce it through his own efforts.

To stay in a store and wait for customers was more than this veteran could endure. We encouraged, therefore, a change in vocation to craftwork—a change which was acceptable to the veteran only after he lost part of his guilt feelings.

The Depressive Type

Different clinical pictures appear in veterans with different defensive mechanisms, and their attitude toward a job varies accordingly. Our first veteran's behavior was characterized by a "counter-phobic attitude,"

projection and denial of fear and guilt. Here is the reverse picture, the mechanism of turning aggression against one's self.

Case 2. This veteran was suffering from an intense depression and crying spells. He spoke of his feeling of guilt and anxiety at being out of the service, when he appeared so healthy and when other men were being killed. He had undergone harrowing combat experience, standing nine days on a pontoon tug, nearly drowning, and seeing dead bodies all around him. His claim for compensation was rejected and he expressed a great deal of resentment about this. He needed it in order to justify his absence from fighting and because of the attitude of practically everyone he met. People could not understand what was wrong with him; they thought he was trying to lay off and exploit his status as a veteran. "My adjustment would be much easier if I had a maiming wound of some kind."

In contra-distinction to the first case, he could not write or keep up contact with his outfit. He continuously tried to justify his discharge, whereas the first one at least consciously overdid himself in defying anybody who would doubt his right to be at home. The second outstanding difference is that since the first patient wanted to be a civilian, his resentment was directed against the Army and the Government, while this veteran felt he should do more for his country and his buddies, and, therefore, expressed his resentment against civilians. He felt consciously guilty for wanting to be a civilian and, therefore, had a feud with civilians. Accordingly, he looked for some menial job, humiliated himself continuously, and by working nights, an attempt to conquer his insomnia, defeated his adjustment. He was interested in compensation in order to relieve the tremendous guilt from which he was suffering.

After a number of psychotherapeutic sessions we decided to offer him group therapy, while continuing with individual psychotherapy, and to prepare him for a change in his vocation. But suddenly a veterans' organization encouraged him to appeal his compensation and ask for a certificate supporting his appeal. Since our policy is to avoid involvement in the technical side of compensation problems, we were unable to give him the statement which he requested as to how far his disability was service-connected. Subsequently, he dropped out of treatment.

This veteran wished he had a physical injury. The first of the above cases was injured in combat. This seemed to protect him against breakdown, an observation which we made in some other cases. His second injury, however, since it was "accidental," only increased his moral conflict.

Compulsion Neurosis

The next veteran was suffering from a compulsion neurosis which was intensified by combat experience.

Case 3. This veteran was put in charge of a machine gun section of fifteen men. He was in actual combat for three months and took it well until suddenly his section was wiped out. Thirteen of the fifteen men were killed. He was conscious of all that was going on but felt paralyzed, so that he was unable to reach for his gun either as a defensive or offensive measure. Another outfit came up just in time to pull the

necks of the remaining three "out of the noose." At that point he "blacked out" and couldn't remember anything until he came to, a week later, in a hospital behind the lines. He continually relived the traumatic experience and even now, two years later, he is very nervous. He feels he will "blow his top" at any moment and possibly kill someone in a fit of temper. At night the vision of the terrible experience comes back to him vividly and he wakes up in a cold sweat. He gets panicky and wants to "hit the floor whenever a plane flies low overhead or a siren blows," etc. He is no way bitter about his service experiences: there was a hasty job to be done and he was one of those who helped do it. If he could get back in the service to finish it up he would, and he would enlist in the Marines again. He maintains compulsive loyalty to the men who died in his battalion. He has to work overtime each day in order to help the war effort. Sometimes when he is so unnerved and shakes so badly that he has to stop working for the day and go home to get hold of himself, he is worried because aside from the personal inconvenience "he doesn't do the war effort any good." As long as he can't be out there fighting, he wants to help the boys who are fighting by doing his part at home. He was extremely reluctant to accept treatment and came to the clinic primarily for the purpose of having his disability rating restored. This has been reduced to less than a fourth of the original amount. This veteran derived a great deal of satisfaction from his work due to the relief of his guilt. We encouraged him to keep to his vocation.

Compensation Problems

In most of our cases the question of compensation did not play an outstanding role. In the few cases we observed it was obvious that the psychological meaning of compensation was closely connected with a moral conflict regarding the veteran's desire to prove his merits. In the second of the above cases it was the direct reason for interruption in the veteran's treatment. This is even better demonstrated by another case where the veteran did not ask for support of his claim, but frankly admitted that he could not start treatment before the final settlement of this question.

Case 4. This veteran airman had all the symptoms of a severe traumatic war neurosis: insomnia, terrible nightmares, extreme restlessness, irritability with everyone, extreme sensitivity to any kind of noise, and severe headaches. He was shot down after eight missions over enemy territory. He bailed out from the burning plane and went through harrowing experiences for six weeks making his way back to our lines and escaping capture. He admits that his war experiences are constantly on his mind, even though he tries to forget them. His symptoms become worse whenever he talks of his experiences. He was very critical of the treatment he received in the Army, saying that many doctors talked with him and no one could help him. He was seen only twice in our clinic and came for the third time to tell us that his claim would be subject to examination after another five or six months and to ask if we could do something to speed it up. Were he to get better, his pension would automatically be cut. However the Veterans' Administration made it clear to him that a final settlement would have to wait, since it has been their experience that most cases improve a great deal after six months. Since we couldn't do much about this he flatly refused treatment.

Group Therapy

Before we describe the preventive measures which could be planned for on the basis of our observations, we should like to give an excerpt from a discussion of problems of compensation in group therapy.

The group started the discussion tonight with the question of pensions. This was a continuation of what had gone on prior to the psychiatrist's arrival, while the boys were gathered in the waiting room. The group consisted of five veterans, two of whom (A & D) were combat casualties, the others having broken down during service in the United States. The psychiatrist's questions are marked with "Q":

A: Some of the boys deserve more compensation than the others.

Q: How would you determine how much a man deserves?

A: It should be on one principle: if he is handicapped in the type of work he did before.

B: Those who have a physical disability should get a compensation anyhow, because they never know how long their efficiency may last. The man better equipped physically will just naturally get a better job.

Q: You feel that only the physically disabled should get compensation?

B: Some men might depend on a pension too much and might not try to get well. They might not be conscious of what they were doing.

Q: How is that possible?

C: He might do it subconsciously.* The subconscious is disorganized, lazy, and has streaks of cruelty. It is a very primitive sort of thing.

Q: Why shouldn't they try to get well?

C: It's a form of escapism.

A: It's foolish for a man to cut down his earning capacity.

C: Your subconscious mind doesn't do things that way.

Q: How should we understand that?

B: Such boys feel that they are owed something. It doesn't have to be any logical reasoning. They just feel they are entitled to it, and that has control over their minds. The more you think about it the more you want it, and the more you get entangled in it. It is not so much the idea of getting money, but a feeling of bitterness you have.

Q: What is the reason for such a feeling?

C: One reason for their bitterness is the fact that all they have done is forgotten, overlooked, and unappreciated. No one gives a damn. To the people back home the war and what you have done mean nothing.

Q: Do you feel that greater compensation would help them to get over this feeling of bitterness?

D: That would hurt them more than anything else. I would say you were babying them. If you gave them everything on a silver platter they would expect it and you would be babying them. Compensation would be of no help. They should get a lump sum. The men who have lost an arm or leg are the ones who are really bitter.

Q: Aren't you contradicting your statement which you made at our last meeting here? Do you still remember what you said about being crippled?

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* This veteran was not "indoctrinated" in our Clinic. We had no discussions about the "subconscious" in the group.

D: I remember, but you see, you can't help feeling guilty if you are not crippled. Those who have not been overseas are lucky. They haven't suffered and seen terrible things; I have bombed women and children. It just couldn't be helped. You couldn't destroy Hamburg or Bremen without killing women and children. There were 125 men in my group, and 113 were killed. The idea is that I feel I have let them down. I am not still there. I still get that feeling when I see service men—of being guilty in being out before it's over. I can't do anything. I am out. I am through.

B: I can't understand that—how a man who had combat duty should feel that way. After all, you have been shot through the lungs and wounded in your right hip and arm. If you hadn't been wounded I could understand it.

D: But it doesn't show. I am all right. If I would have lost a leg or arm I would have felt I had done my duty. I would be in a much better position than I am now.

A: Those who have been disabled physically should get more compensation.

D: All those who don't have a right to be bitter will be bitter too. Those sitting around in bars, fighting "the battle of Hamilton Field" or "March Field." They have never been out of the United States and they are always squawking about wanting to go overseas, when there is nothing to stop their going.

A: What about this group? Would they feel bitter about compensation?

D: They want compensation in order to feel they can be sure of being part of the job. To them, compensation is just a certificate of merit, a substitute for a citation.

Q: Will the compensation help them?

D: Oh no. Well, take me for example. I just expect a compensation.

Q: Does it cut down your real initiative?

D: Maybe it does. As long as you get a compensation you feel you are not getting enough. If you are given a bonus, one lump sum, you are not being reminded each month by receiving a meager sum of money, and there will be no feeling of bitterness.

Q: Have you any comment on this?

E: I consider the compensation a gift to myself. However, I felt I should keep it, in order to look out for and protect the rights of the other fellow.

Reconditioning Program

Grinker and many others have made the observation that most combat cases get worse as they are removed from the zone of combat. In spite of this, a number of veterans are discharged with the hope that their symptoms will disappear after they return home. Some get well but many others have a relapse after futile attempts at readjustment, and others, of course, do not get well. As a matter of fact their neuroses tend to become fixed. The excellent rehabilitation and reconditioning program outlined by the War Department takes the soldier's intense moral conflict into consideration both in individual and group therapy, as well as in the educational program. The soldier's reaction to his superior officers—his feelings of rebellion and resentment—the reaction to the death of his buddies, are thoroughly discussed.

Nevertheless, in the cases which come to our attention the struggle with these feelings continues after discharge. The veterans behave as if their symptoms were an unconscious expression of a rebellion against authority, a sign of disobedience for which they expect disapproval or punishment. A process of secondary elaboration—an attempt to justify their breakdown—sets in regardless of whether or not an individual obtains compensation or has no conscious reaction to the financial aspect of his disability. There is a tendency on the part of the veteran to use his suffering to relieve his guilt and prove his innocence. He is torn between the feeling that he should be in service and the contrasting desire to be discharged. These two sets of ideas conflict with each other and are often projected into the environment. Many times, of course, the environment makes it very easy for the veteran to accomplish such a projection. The civilian is struggling with the same conflicting attitudes, either provoking the veteran or responding to the veteran's provocation, questioning him about his discharge, blaming him directly or indirectly for being out of service, or making him feel very guilty by being oversolicitous, a concern which many veterans feel they do not deserve.

The Community's Part

Recognizing the conflict between veterans and civilians, we have worked with both groups to promote their mutual understanding. The Clinic helps the community itself to respond to the veterans' needs, through such means as organizing and participating in lectures and courses for interested agencies. It also offers the veteran direct help in the "transition period" between Army and civilian life, as described in the following article by Miss Rhode.

This work in the community and the reconditioning program in the Army are effective methods of prevention, but much more has to be done. Counselors in the United States Employment Service, training officers dealing with the rehabilitation of veterans, personnel managers in industry, and workers in social and recreation agencies should be better acquainted with the problems of veterans, with their conflicting ideas concerning the war and discharge. While it is true that the origin of the veterans' moral conflict can be found in impulses of their early childhood, it should not be forgotten that the problems of merits in the actual fighting and of rights to return home are not altogether imaginary. Veterans are confronted daily with civilians and soldiers who discuss with them these problems which the veterans are unable to face due to their entanglement in their neuroses. We fear that a high percentage of veterans will for such reasons simply refuse treatment or even refuse to recognize their difficulties. Unless properly prepared they will tend to seek only compensation and never achieve rehabilitation.

It might also be possible to increase the efficiency of the rehabilitation and reconditioning program of the Army by including in group therapy the topic of soldiers' reactions to discharge—their feeling of guilt for leaving the service, their fear of failure in readjustment, common mistakes in the selection of a vocation, the psychological meaning of compensation and suffering, the attitude of civilians to veterans, etc. We are aware of the fact that psychiatrists in the Armed Forces, concerned as they are with salvaging as many men as possible, might not be able to deal effectively with these problems while the question of discharge remains unsettled in the soldiers' minds. In spite of all these obstacles, preventive treatment, particularly in the form of group therapy, could be effective. Individual therapy is not only time-consuming but also inadequate in dealing with such acute social problems. Group therapy, as exemplified in the excerpt given above, brings a quick and effective insight into the conflicts veterans have to face after discharge.

Summary

The clinical picture observed in veterans discharged for psychiatric disability is usually determined by the individual's pre-war personality. This is demonstrated by three different types of traumatic war neurosis. One case of a "counter-phobic attitude," another of a depression, and an example of a compulsion neurosis are described. We have observed the clinical picture of an "hysterical psychosis" as a transient reaction to discharge which seems to have no relation to the individual's pre-war personality.

We use in the Clinic short individual psychotherapy, supplemented by group therapy. These therapeutic procedures are only part of the rehabilitation program. An example of "selective vocational rehabilitation" is outlined. An excerpt from group therapy is reported to illustrate its usefulness in dealing with problems of compensation and the possibility of using group therapy as a preventive treatment prior to discharge.

COMMUNITY ASPECTS OF THE VETERAN'S READJUSTMENT

By CHARL RHODE*

Rehabilitation—even psychiatric rehabilitation—cannot be accomplished within a clinic or from behind a desk. The process merely is set in motion there, while the actual rehabilitation is achieved in the community in social and recreational activities and in work.

In the first place, the problems which bring a man to a rehabilitation clinic usually are problems of concern to the community, either immediately or ultimately. There are, for instance, the varied difficulties centering around employment and often manifested by criticisms, complaints dissatisfactions, or frequent shifting from one job to another. Or the veteran may remain quietly on a job not in keeping with his experience, ability, or interests, with resultant unhappiness, worry or strains affecting not only his work but also his life away from his work.

Employment is a matter of frontline importance for our society but there are many other readjustments incident to a man's return to a family, a social setting, an economic structure, all of which probably have changed since he left and which, in any event, are different from that environment and those relationships which characterized his military experience. Added to this are the peculiar and enormously vital psychological factors involved in a man's leaving a military setting during wartime—conflicts centered both around the discharge and around the subsequent relationship with civilians. All of these problems are touched upon by Dr. Bowman, Dr. Kasanin and Dr. Windholz in the preceding papers and are illustrated briefly in the cases below. They are well known to all who work with veterans.

For many veterans there will be only a transient groping to reach some kind of firm footing in the civilian world. For others it will be a difficult process, and the more prolonged it becomes the greater will be the accumulation of both actual experiences and psychological attitudes unfavorable for the veteran's ultimate restoration. It is for the group of men who somehow are not able to bridge the gap easily that psychiatric rehabilitation assumes immediately significant proportions. However, every veteran in his return to civilian life brings along with him a special psychology growing out of his military experience and therefore not duplicated in civilian life. From a careful study of those veterans who present psychiatric problems, it should be possible to learn much that will contribute to a better understanding of the problems of all veterans.

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There has been much controversy about the possible overemphasis on "problems" of veterans, especially veterans with neuropsychiatric disabilities. Certainly not all will have or be problems, but there will be few who can—or will want to—pick up just where they left off. The difference between civilian and military life, especially for the combat soldier, is too great to permit a simple transfer in either direction. Even Bill Mauldin†, who protests against the idea of any problems among the veterans, describes the infantrymen whom he knows so well as "not the same guys who left years ago" and as needing "bosses who will give them a little time to adjust their minds and their hands, and women who are faithful to them, and families who stay by them." These needs, in one degree or another, represent the essential core of rehabilitation.

In no event can a soldier become a civilian again without touching the lives of others at many points. Rehabilitation, then, becomes a matter in which others share, either through formal planning or in spite of themselves.

Community Relationships

From the beginning, cooperative relationships with community groups interested in the veteran‡ were a prominent feature of the program of the Veterans' Rehabilitation Clinic. This has been true not only with regard to the veterans under treatment in the Clinic, but also with regard to outside programs of a general educational nature. The chief psychiatrist or the chief psychiatric social worker, or both, had frequent conferences with psychiatrists, psychologists, social workers, counselors in industry, educators, recreation workers, and representatives of regional or federal agencies, in relation to rehabilitation problems and services. They participated in many lectures, panel discussions, or meetings, involving such organizations as:

Alcoholics Anonymous
American Red Cross
American Women's Voluntary Services
Bureau of Vocational Rehabilitation
California Labor School
Cathay Post, American Legion
Community Chest
Family casework agencies
Junior League
Maritime Service
Mental Hygiene Society
National Travelers' Aid Association
Port Medical Office
Psychiatric Social Workers of N. Calif.
United Service Organizations
United States Employment Service
United States Public Health Service
University of California (Veterans' Institute)
University of California School of Nursing
Veterans Administration
YMCA
YWCA

† *Up Front.* By Bill Mauldin. New York: Henry Holt, Inc. (1945).

‡ The term "veteran" as used herein includes merchant seamen released from duty as well as discharged servicemen and women. The Clinic made no distinctions except where technical provisions were involved in the services of cooperating agencies.

The chief psychiatrist assisted with a special training course of the AWVS for rehabilitation aides. The Clinic was an active member of the San Francisco Coordinating Council for Veterans' Services.

Several of the industrial centers around the Bay area sought direction from the Clinic in the organization of their local services for veterans. The psychiatrist and social worker took part in general "coordinating" meetings in such communities, or met with civic and welfare leaders who came into the Clinic to discuss their community planning for veterans.

Recently one of the large naval installations using civilian employees approached the Clinic regarding a possible cooperative study and experiment in the field of veteran employment. Preliminary discussions are now under way on this matter.

One special project undertaken jointly with the YWCA developed out of a striking lack of social resources for the veteran in contrast to the widespread activities for the serviceman, such as those provided by the USO clubs. The Adult Recreation Director of the YWCA expressed interest in working out a social-recreational program for veterans, to be merged eventually with the regular programs for civilians. Initial planning was done by the recreation director and the psychiatrist and social worker from the Clinic. The hostesses from the YWCA, in order to establish a liaison, set up a refreshment canteen in the evening clinic where about 35 veterans had appointments each week. These hostesses discussed the project with the veterans. Subsequently some of these veterans joined with others in the city to plan their own activities. Beginning with a few small groups, this developed into a varied and extensive program, operated jointly by the veterans and the hostesses. Initial financing of both the canteen and the activities was carried by the YWCA. The expense of the canteen was assumed later by the Clinic and expenses of the recreational program were met by the veterans' group, which had organized as a social club with the usual committee structure and with its own printed publicity. There was a surprising response to this project, which proved to be something of a stepping-stone into a broader social outlet for those veterans who had not been able to achieve this directly by themselves. The hostesses continued to come into the evening clinic on a rotating basis in groups of three, and the social worker in the Clinic assumed responsibility for coordinating the programs.

The general interest of the community in the Rehabilitation Clinic was indicated not only by the contacts described above but also by the variety of referral sources. Within the first six months of operation, veterans had been referred by about 50 individuals—physicians, friends, relatives, and employers—and about 25 organizations.

Vocational Placement

A working relationship was maintained with many of these organizations, either from the time of referral or initiated later by the Clinic when the service of the particular organization seemed important for the veteran. The most common collaboration was with the Vocational Counseling Service of the USES and with the Bureau of Vocational Rehabilitation of the State Department of Education. Vocational testing and at least temporary placement in a training unit or job, as arranged through either of the vocational services, often was part of the early program outlined for the veteran in the Clinic. Such placement was based on initial testing combined with a psychiatric study of the emotional conflicts related to employment. Cooperative planning of this kind appeared to make good use of the special facilities of the Clinic and the special facilities of the vocational agencies, who knew the job market and the job potentialities, and could arrange practical details with employers. Often it required a period of psychiatric treatment and a period of various experimental placements before a solution was found, as illustrated in the following case:

A 23 year old veteran was referred by the Bureau of Vocational Rehabilitation with various physical complaints and symptoms of marked anxiety. He had been discharged a year previously after three years in the Armed Forces. A psychiatrist who had examined him diagnostically several months before this referral recommended that a retraining program be deferred until the patient's anxiety had lessened. At the time of referral to our Clinic he still was unable to work regularly and his family had refused to help him further.

The veteran was placed on several successive jobs on the basis of vocational test results, but because of his emotional disturbance he left each one shortly. In the Clinic he was seen weekly by a psychiatrist who, in the course of treatment, was able to make recommendations regarding the type of work most suitable for the veteran in terms of his particular conflicts. The social worker, who was in close touch with the psychiatrist, also maintained regular contact by telephone with the training officer at the Bureau, who was supervising the patient's vocational program. Thus the social worker, who was familiar with the progress and the problems in both areas of the patient's treatment, was in a position to help coordinate psychiatric and vocational services into a practical rehabilitation program for the veteran. As we understood more of the conflicts which interfered with the veteran's satisfactory job performance it was possible for the training officer to make placements which took these, as well as the testing, into consideration. At the same time the psychiatric treatment made it possible for the veteran to handle these placements more satisfactorily.

Often the Rehabilitation Clinic carried on a treatment program with the veteran for several weeks before he was able or ready to make use of other resources. With the groundwork laid during that time he might then take responsibility himself for any other contacts necessary in his readjustment.

A 28 year old veteran was referred by the Red Cross because of nervousness, difficulty in making any kind of adjustment, and an irregular work history. At the time of the initial contact with the social worker in the Clinic he asked for help with housing, finances, recreational contacts, and employment, as well as for treatment of his "nervousness." The social worker made suggestions regarding all of these requests but the veteran did not follow up on any of them. He was assigned to a psychiatrist for regular interviews and during the course of treatment again made similar requests, which were handled in a similar way, with similar results. However, the social worker discussed the veteran's respective problems with the appropriate organizations, and discussed with the veteran the procedure involved in obtaining the different services he wished, as well as the name of a particular person in each place with whom he might talk.

After a period of several weeks of psychiatric treatment the veteran spontaneously acted upon all of the earlier suggestions, including a job referral tentatively outlined by the Clinic and the veterans' interviewer at the USES. Soon after this psychiatric treatment was terminated, but in the following months the veteran periodically called or came in to see the social worker 'to let her know how things worked out'. When last seen, six months after termination of treatment, he was working steadily on the job he had accepted, had married, and seemed generally quite happy.

Planning with the Employer

This spontaneous contact after the period of active treatment was characteristic of many of the veterans, especially where the initial interview was with the same psychiatric social worker. Occasionally it was the social worker rather than the veteran who took responsibility for this kind of contact, especially in cases where it was believed this would be helpful in stabilizing the veteran's adjustment. As indicated in the following case, the social worker might also keep in touch with a significant individual in the veteran's environment.

A veteran who had been unable to work at all during the several months since his discharge finally decided to come to the Clinic for help. After a few initial interviews with the psychiatrist and with the social worker regular interviews were planned with the social worker. During this period he was overwhelmed by anxiety whenever a job referral was suggested by the USES. After three months of treatment, carried on in close consultation with the psychiatrist, the veteran accepted an important position in industry. It was recognized by both the veteran and the Clinic that he would encounter difficulties on the job if the responsibilities increased too rapidly. With the veteran's consent the social worker discussed this with the employer who expressed willingness to make whatever readjustments were necessary. The social worker kept in touch with the employer and the veteran for a month or two but this supervision was tapered off as things appeared to be going smoothly.

Several weeks later the veteran returned to the Clinic in a rather acute state of anxiety. He was not able to perform his duties satisfactorily, had asked the employer to relieve him of certain responsibilities, and was absent from work frequently. He wished to resume interviews with the social worker and in the course of a few weeks showed improvement. He still was irregular in his attendance at work, however, and the employer became impatient. The veteran asked the social worker to discuss the whole matter with the employer. During the next few weeks,

while interviews were continued with the veteran, the social worker talked frequently with the employer. An important aspect of these discussions was the recognition by the Clinic of the practical problems this situation presented for the employer. A compromise eventually was worked out which was agreeable to both veteran and employer. Before long there was marked improvement in the veteran's work performance and in his attitude toward his work. He began to come to the Clinic less often for interviews, instead telephoning from time to time to report his progress. Two months after his return he had terminated treatment and a month later he telephoned to report that he had received a very good performance rating on his job.

Combined Resources

There were not many cases in our Clinic where treatment consisted entirely of psychiatric interviews. Almost always there was a combination of therapeutic effort: on the one side between psychiatrist and social worker within the Clinic, on the other side between the Clinic and the family, the employer, or others in the community. This pooling of all efforts, so necessary for rehabilitation, is exemplified in the following case:

A 21 year old veteran was referred by the Veterans' Administration because of extreme tension, fear of failure, excessive difficulty in making decisions, feelings of discouragement and depression, inability to work, and various physical complaints. These symptoms had increased in intensity during the year and a half since his discharge. An immediate program of psychiatric treatment was begun, but the usual weekly interviews scheduled in our Clinic were not sufficient in this case. Because the psychiatrist could not see the veteran more frequently a plan was worked out for interviews with the psychiatric social worker as well. The patient understood that there was full discussion between these two, as well as with the chief psychiatrist, yet there were interesting and significant differences in his interviews with the man psychiatrist and the woman social worker. These differences were illuminating in a study of the psychodynamics of the patient's conflicts.

In his contact with both the patient talked of his personal problems and also asked for help in relation to jobs, vocational training, housing, finances, and recreation. He was not able, however, to participate in any of the usual social, recreational, or even casual, relationships with people, although he responded almost overwhelmingly to the interest of the psychiatrist and social worker. It was obvious to the Clinic staff and to the patient himself that psychiatric treatment was essential before any other planning could be done. Psychiatrist and social worker worked very closely together in the treatment. An attempt was made to include the veteran in group therapy, but he did not respond favorably.

This patient had been orphaned at an early age and had spent most of his life in boarding schools. He showed in all of his interviews a frank longing for a home and for family ties. It seemed to the staff that a family setting, carefully selected and with opportunities for counseling in regard to any problems which might arise, would offer therapeutic value in such a case. The social worker discussed this idea with family agencies, with community centers, and with groups of women serving on committees of professional organizations. As visualized the plan would involve continued psychiatric treatment of the patient and close cooperation between the Clinic and a family agency which would assume responsibility for counseling with the family. The patient himself was delighted with the idea. The plan still is in a preliminary stage.

By the end of five months there was marked improvement in the patient's physical symptoms and in his general responsiveness. He seemed ready for broader planning, which was talked over between psychiatrist and social worker and with the patient. Working at the patient's tempo the social worker helped to arrange recreational activities through the YMCA, the YWCA, and a special music group; financial aid through the Red Cross and the Bureau of Vocational Rehabilitation; housing through the YMCA and one of the housing agencies; special casework and employer contacts through two agencies represented by volunteer social workers in the evening clinic; special temporary employment through one of the unions; and vocational training through the Bureau of Vocational Rehabilitation working closely with the Clinic. For the first time in months, the veteran began working and began to establish relatively satisfying personal contacts. His dependence on the Clinic diminished but the social worker continued to keep in touch with his progress.

It seemed likely that this veteran would continue to need some supervision, practical assistance, and casework service for some time to come. The Clinic was not equipped to give long time services of this kind and it was believed that the patient needed a permanent resource in the community to which he could turn for whatever help he needed. This was discussed with a family casework agency, and eventually the case was accepted by them. It was anticipated that the transfer would not be simple for the veteran because of his attachment to Clinic staff, but the fact that a worker from the family agency was a volunteer in the evening clinic facilitated the transition. Meanwhile, psychiatric treatment would be continued in the Clinic as long as necessary.

In the course of less than a year of operation it was clear that the community was becoming aware of the problems of rehabilitation, and that rehabilitation was a process in which the community inevitably played an important part. It was clear also that such a Clinic could be a sort of catalyst in the community—stimulating awareness, clarifying problems, and coordinating psychiatric help with other services.

BOOK REVIEW

Manual of Diagnostic Psychological Testing: I. Diagnostic Testing of Intelligence and Concept Formation. By David Rapaport, PhD., with the collaboration of Roy Schafer and Merton Gill, M.D. New York, Josiah Macy Jr. Foundation, 1944. Review Series, Vol. II, No. 2. Pp. 239.

Considering the limitations under which the authors inevitably worked in preparing the Manual quickly for the use of the armed forces one cannot but be highly impressed with the achievement. Aside from certain minor considerations which need not be discussed in a brief review we have here the first really sophisticated manual of psychometric testing to be published. For the first time are various tests of intellectual function integrated into the general body of personality analysis and made to deliver up more than the I.Q. and the few casual unorganized qualitative statements with regard to some formal aspects of the personality which has so largely been the contribution of psychometrics.

The tests considered in this volume are the Bellevue Scale, the Babcock test, and three concept formation tests: the Similarities test (Bellevue), the Sorting test, and the Hanfmann-Kasanin Test. For each of these tests the findings are presented for 19 types of maladjustment and a normal control group. Two further volumes are promised, one to contain a discussion of projective personality tests and the other, sample diagnostic analyses of clinical and psychological examinations of patient and control subjects.

In an introductory section entitled "Clinical Considerations" a very helpful discussion of the rationale underlying clinical testing procedures is followed by a description of the test battery and of the case material used in the study.

The next section, on "Intelligence Tests," begins with a set of nine assumptions which essentially constitute the authors' conceptual base for diagnostic intelligence testing. They follow through the implications of these assumptions in the discussions which follow of the Bellevue Scale and the Babcock Test. Under each, the description of the test emphasizes the features of special significance for diagnostic intelligence testing, the rationale of the various sections and items are discussed mainly in respect to the functions underlying achievement, supplementary administrative suggestions are proposed, and general descriptions of profiles and patterns are presented. Three types of analysis are considered: *scatter*—analysis of deviations of subtest scores from each other; *item*—analysis of particularly easy items for significant failure; *qualitative*—analysis of responses which by their unusualness have diagnostic significance in helping to differentiate between lack of attainment, temporary inefficiency, impairment and deterioration.

The last section, on Concept Formation Tests, begins with a succinct but clarifying discussion of the rationale of concept formation in relation to maladjustment, as seen from the logical viewpoint and as exemplified in the three tests used.

After a brief consideration of the Similarities Test of the Bellevue Scale, the authors concentrate on the Sorting and the Hanfmann-Kasanin Tests.

Descriptions of these tests are followed by a consideration of the rationale underlying each, both as to function and scoring, test administration and the findings with respect to diagnosis. The section closes with an evaluation of patterns of achievement on this group of tests.

The above description of content gives only a limited notion of the amount of valuable data and keen psychological analysis which are to be found in the volume. It is unfortunate that war conditions prevented the manual from being published in a more attractive and usable format. But this is a secondary consideration. One hopes that the persons for whom the manual was intended were sufficiently prepared to take advantage of the wealth which it contains. After this sample, one cannot but look forward to the appearance of the subsequent manuals in the series. One looks forward even more, however, to the promised detailed monograph which presents the material in complete scientific fashion.

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BOOK NOTICES

Rorschach's Test. I. Basic Processes. By S. J. Beck. Price $3.50. Pp. 223. New York, Grune & Stratton, 1944.

This volume is a technical manual describing the scoring categories of the Rorschach Test. It supplies a real wealth of sample material for each score. Beyond doubt it fulfills well the need that thus far only Richers-Owsienhiva's mimeographed sample collection, now out of print, served. Doctor Beck's careful and conservative work adheres closely and in a praiseworthy manner to Rorschach's original work. (D. R.)

Motivation and Visual Factors, Individual Studies of College Students. By Irving E. Bender, Henry A. Imus, John W. M. Rothney, Camilla Kemple, and Mary R. England. Price $4.00. Pp. 369. Hanover, New Hampshire, Dartmouth College Publications, 1942.

The aim of the study reported in this rather bulky volume was to see whether the motivations of college students are influenced by their visual handicaps. The results are negative except for, "The evidence indicates clearly that the motivational pattern of the individual does influence his adjustment to his visual condition." (Page 318) . . . "subject's report of severity and extent of his symptoms is more closely allied to his motivational pattern than to the degree of his visual defect." Beyond these rather noncommital conclusions, the twenty cases that are reported one by one are carefully worked out with manifold testing and investigating methods being applied. Psychiatrists and clinical psychologists will enjoy reading the clearly written character profiles and integration in them of clinical and testing data. The whole issue of visual problems appears to be quite peripheral to this work. (D. R.)

Manual of Military Neuropsychiatry, Edited by H. C. Solomon and P. I. Yakovlev. Price $6.00. Pp. 764. Philadelphia, W. B. Saunders Co., 1944.

Forty-five neurologists and psychiatrists have contributed chapters to this symposium which was originally a course of refresher lectures for physicians assisting induction stations or contemplating military service. It is excellently organized by the editors in relation to induction, administration, diagnosis, treatment and such special topics as morale, electro-encephalography, occupational therapy and the psychosomatic aspects of tropical diseases. Inevitably it has some weak spots, for example the inadequate and misleading presentation of homosexuality, but in general it represents American military neuropsychiatry proudly and well. (K. A. M.)

Children's Behavior Problems. II. Relative Importance and Interrelations Among Traits. Behavior Research Fund Monographs. By Luton Ackerson. Price $5.00. Pp. 570. Chicago, University of Chicago Press, 1942.

This is a lithographed statistical study of 3,294 consecutive cases of the Illinois Institute of Juvenile Research. The first volume of the study, based on 5,000 cases dealt with incidence of, genetics of and intellectual factors in, maladjustment. The present study deals with intercorrela-

tions of 125 symptoms, syndromes, appraisals, prognoses, traits, etc. The author is praised by the editor for having "in truly scientific spirit" undertaken this study "without a conceptual framework or hypothesis." This pragmatic pseudo-science bore its fruits: mechanical correlations were obtained between entities which were not systematized even to such degree as to assure that a correlation obtained will be meaningful. This huge volume is a monument to a tremendous wasted effort and to the dangerousness of statistics when they are allowed to replace thinking instead of implementing it. (D. R.)

Crime and the Human Mind. By DAVID ABRAHAMSEN. Price $3.00. Pp. 244. New York, Columbia University Press, 1944.

The author presents a rather condensed summary of the history of criminology and particularly of the psychiatric and psychological point of view in criminology with some suggestions of his own borrowed, as he frankly says, from this Clinic and elsewhere, for the routine examination of the personality structure. A classification of offenders more practical than strictly nosological is also offered. The book is nicely printed; the index is somewhat defective. (K. A. M.)

Development in Adolescence. By HAROLD E. JONES. Price $2.00. Pp. 166. New York, D. Appleton-Century Company, 1943.

This book is a report of the California Growth Study. It takes the form of a description of the development of one boy, John Sanders, the rest of the population of the Growth Study serving only as a background. The report is characterized by the fact that inferences are drawn from behavior observations and their rating on the one hand, and from inventories on the other. We do not learn what John's experiences were. A remarkable poverty in the intellectual evaluation of John, in the treatment of the intelligence and achievement tests, and a quite good appraisal of the projective personality tests is an instructive contrast. While the lack of the inside story of John will be deplored by the psychiatrist and the modern clinical psychologist, the careful collection and organization of behavior data and social data is certain to be found interesting and instructive from the point of view of method. (D. R.)

Rehabilitation of the Tuberculous. By H. A. PATTISON. Price $2.50. Pp. 186. New York, Livingston Press, 1943.

This is an interesting portrayal of the road to normal living for the tuberculous individual. The technical aspects of medical therapy are not considered, but the author shows the contribution made by sanatoria during the past thirty years in evolving the present patterns for rehabilitation which are becoming more successful as they are more generally applied. Physical or mental work prescribed as treatment is discussed. The factors of the human constitution, allergy and immunity, the mental aspects of tuberculosis, and marriage of the tuberculous are all approached from the point of view of their relationship to rehabilitation. The author has been liberal in presenting the findings of colleagues in order to develop or strengthen his points. The book contains a brief resume of approximately eighteen programs for rehabilitation of the tuberculous which are in operation at home and abroad. (J. R.)